		FOR OHF USE					

LL1

2003
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2003)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0032789

Facility Name: SHARON HEALTH CARE ELMS

Address: 3611 n. Rochelle (Number) Peoria (City) 61604 (Zip Code)

County: Peoria

Telephone Number: (309)685-4412 **Fax #** (309)688-4950

IDPA ID Number: 363530585001

Date of Initial License for Current Owners: 08/15/087

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rick Duros **Telephone Number:** (847)441-8200

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/03 to 12/31/03 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Rick Duros
(Title) CFO

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	30,546	1,039	222	31,807	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	30,546	1,039	222	31,807	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 88.92%

D. How many bed-hold days during this year were paid by Public Aid?
54 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 8/15/87

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 8/15/87 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/03 Fiscal Year: 12/31/03

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	168,655	19,734	8,757	197,146		197,146		197,146			1
2	Food Purchase		142,813		142,813		142,813	(1,883)	140,930			2
3	Housekeeping	107,014		14,166	121,180		121,180		121,180			3
4	Laundry	72,688	23,650		96,338		96,338		96,338			4
5	Heat and Other Utilities			88,110	88,110		88,110	726	88,836			5
6	Maintenance	57,893		43,177	101,070		101,070	2,144	103,214			6
7	Other (specify):*											7
8	**TOTAL General Services**	406,250	186,197	154,210	746,657		746,657	987	747,644			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,362,811	128,228	27,466	1,518,505		1,518,505		1,518,505			10
10a	Therapy											10a
11	Activities	41,991	2,150	2,739	46,880		46,880		46,880			11
12	Social Services	67,070		4,733	71,803		71,803		71,803			12
13	Nurse Aide Training		(351)		(351)		(351)		(351)			13
14	Program Transportation			4,852	4,852		4,852		4,852			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,471,872	130,027	45,790	1,647,689		1,647,689		1,647,689			16
	C. General Administration											
17	Administrative	88,244			88,244		88,244	44,480	132,724			17
18	Directors Fees											18
19	Professional Services			17,053	17,053		17,053	226	17,279			19
20	Dues, Fees, Subscriptions & Promotions			9,454	9,454		9,454	(1,194)	8,260			20
21	Clerical & General Office Expenses	76,126		60,133	136,259		136,259	(12,722)	123,537			21
22	Employee Benefits & Payroll Taxes			261,668	261,668		261,668		261,668			22
23	Inservice Training & Education											23
24	Travel and Seminar			1,355	1,355		1,355		1,355			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			43,184	43,184		43,184	86	43,270			26
27	Other (specify):*							5,927	5,927			27
28	**TOTAL General Administration**	164,370		392,847	557,217		557,217	36,803	594,020			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,042,492	316,224	592,847	2,951,563		2,951,563	37,790	2,989,353			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number SHARON HEALTH CARE ELMS #0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			25,896	25,896		25,896	60,991	86,887			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			(18)	(18)		(18)	66,963	66,945			32
33	Real Estate Taxes			38,962	38,962		38,962	3,670	42,632			33
34	Rent-Facility & Grounds			105,083	105,083		105,083	(97,919)	7,164			34
35	Rent-Equipment & Vehicles			14,266	14,266		14,266		14,266			35
36	Other (specify):*											36
37	**TOTAL Ownership**			184,189	184,189		184,189	33,705	217,894			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			53,655	53,655		53,655		53,655			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,042,492	316,224	830,691	3,189,407		3,189,407	71,495	3,260,902			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	665	30		9
10	Interest and Other Investment Income	(1,136)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(1,883)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(1,436)	21		19
20	Contributions	(1,920)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(1,197)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(8,623)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (15,530)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	87,025		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 87,025		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 71,495		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

SHARON HEALTH CARE ELMS

ID# 0032789

Report Period Beginning: 1/1/03

Ending: 12/31/03

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Non-allowable Salary	$ (9,547)	21	1
2	Deferred Maintenance	924	6	2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(8,623)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,883)	0	0	0	0	0	0	0	0	0	0	(1,883)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	726	0	0	0	0	0	0	726	5
6	Maintenance	924	0	0	0	1,220	0	0	0	0	0	0	2,144	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(959)	0	0	0	1,946	0	0	0	0	0	0	987	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	44,480	0	0	0	0	0	0	0	44,480	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	226	0	0	0	0	0	0	0	0	226	19
20	Fees, Subscriptions & Promotions	(1,197)	0	0	0	3	0	0	0	0	0	0	(1,194)	20
21	Clerical & General Office Expenses	(12,903)	0	0	0	181	0	0	0	0	0	0	(12,722)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	86	0	0	0	0	0	0	86	26
27	Other (specify):*	0	0	0	4,473	1,454	0	0	0	0	0	0	5,927	27
28	**TOTAL General Administration**	(14,100)	0	226	48,953	1,724	0	0	0	0	0	0	36,803	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(15,059)	0	226	48,953	3,670	0	0	0	0	0	0	37,790	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	665	0	60,326	0	0	0	0	0	0	0	0	60,991	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(1,136)	0	68,099	0	0	0	0	0	0	0	0	66,963	32
33	Real Estate Taxes	0	0	1,466	0	2,204	0	0	0	0	0	0	3,670	33
34	Rent-Facility & Grounds	0	0	(90,585)	0	(7,334)	0	0	0	0	0	0	(97,919)	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(471)	0	39,306	0	(5,130)	0	0	0	0	0	0	33,705	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(15,530)	0	39,532	48,953	(1,460)	0	0	0	0	0	0	71,495	45

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached		See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V		19	Professional Fees	$	Peoria Forest Partnership	100.00%	$ 226	$ 226	15
16	V		30	Depreciation		Peoria Forest Partnership		60,326	60,326	16
17	V		32	Interest		Peoria Forest Partnership		68,099	68,099	17
18	V		33	Real Estate Tax		Peoria Forest Partnership		1,466	1,466	18
19	V									19
20	V									20
21	V									21
22	V		34	Rent	90,585	Peoria Forest Partnership			(90,585)	22
23	V									23
24	V									24
25	V									25
26	V									26
27	V									27
28	V									28
29	V									29
30	V									30
31	V									31
32	V									32
33	V									33
34	V									34
35	V									35
36	V									36
37	V									37
38	V									38
39	Total				$ 90,585			$ 130,117	$ * 39,532	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$	Redwood Management	100.00%	$	$	15
16	V								16
17	V	17	Management Fees						17
18	V								18
19	V	17	Salary-L.Shlofrock				27,200	27,200	19
20	V	27	Payroll Taxes-LS				3,124	3,124	20
21	V								21
22	V								22
23	V								23
24	V	17	Salary-S.Aron				17,280	17,280	24
25	V	27	Payroll Taxes-SA				1,349	1,349	25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 48,953	$ * 48,953	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	Utilities	$	Barton Management Inc.	100.00%	$ 726	$ 726	15
16	V	6	Repairs and Maint		Barton Management Inc.	100.00%	1,220	1,220	16
17	V	20	Dues, Fees, Subscriptions		Barton Management Inc.	100.00%	3	3	17
18	V	21	Clerical and General		Barton Management Inc.	100.00%	181	181	18
19	V	26	Insurance		Barton Management Inc.	100.00%	86	86	19
20	V	27	Emp. Be. Gen. Admin.		Barton Management Inc.	100.00%	1,454	1,454	20
21	V	33	Real Estate Tax		Barton Management Inc.	100.00%	2,204	2,204	21
22	V	34	Rent Office Space		Barton Management Inc.	100.00%	7,066	7,066	22
23	V								23
24	V								24
25	V								25
26	V	34	Rent	14,400	Barton Management Inc.	100.00%		(14,400)	26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 14,400			$ 12,940	$ * (1,460)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Leon Shlofrock	Owner	Administrative		See Attached			Alloc Rdwd	$ 27,200		1
2	John Shlofrock	Owner	Administrative		See Attached						2
3	Joe Magit	Owner	Administrative		See Attached						3
4	Elisa Shlofrock-Zusman	Owner	Administrative		See Attached						4
5	Jean Shlofrock	Relative	Secretary		See Attached						5
6	Rick Duros	Owner	Administrative		See Attached			Salary	12,711	21-1	6
7	Gary Weintraub	Owner	Legal		See Attached						7
8	Stan Aron	Owner	Administrative		See Attached			Alloc Rdwd	17,280		8
9											9
10											10
11											11
12											12
13								TOTAL	$ 57,191		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Peoria Forest Partnership
Street Address: 465 Central Ave, Suite 100
City / State / Zip Code: Northfield, IL 60093
Phone Number: ((847)441-8200
Fax Number: ((847)441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	19	Professional Fees	Bed Size	585	4	$ 1,350	$	98	$ 226	1
2	30	Depreciation	Bed Size	585	4	360,110		98	60,326	2
3	32	Interest	Bed Size	585	4	406,507		98	68,099	3
4	33	Real Estate Tax	Bed Size	585	4	8,753		98	1,466	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 776,720	$		$ 130,117	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Redwood Management
Street Address: 465 Central Ave, Suite 100
City / State / Zip Code: Northfield, IL 60093
Phone Number: ((847)441-8200
Fax Number: ((847)441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4	17	Salary-L.Shlofrock	Avg Hours Worked	25	5	170,000	170,000	4	27,200	4
5	27	Payroll Taxes-LS	Avg Hours Worked	25	5	19,526		4	3,124	5
6										6
7										7
8										8
9										9
10										10
11	17	Salary-S.Aron	Avg Hours Worked	14	4	69,120	69,120	4	17,280	11
12	27	Payroll Taxes-SA	Avg Hours Worked	14	4	5,398		3	1,349	12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 264,044	$ 239,120		$ 48,953	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Barton Management Inc.
Street Address: 465 Central Ave
City / State / Zip Code: Northfield, IL 60093
Phone Number: ((847)441-8200
Fax Number: ((847)441-0800

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Rental Income	199,800	8	$ 10,075	$	14,400	$ 726	1
2	6	Repairs and Maint	Rental Income	199,800	8	16,921		14,400	1,220	2
3	20	Dues, Fees, Subscriptions	Rental Income	199,800	8	40		14,400	3	3
4	21	Clerical and General	Rental Income	199,800	8	2,513		14,400	181	4
5	26	Insurance	Rental Income	199,800	8	1,187		14,400	86	5
6	27	Emp. Ben. Gen. Admin	Rental Income	199,800	8	20,177		14,400	1,454	6
7	33	Real Estate Taxes	Rental Income	199,800	8	30,584		14,400	2,204	7
8	34	Rent Office Space	Rental Income	199,800	8	98,036		14,400	7,066	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 179,533	$		$ 12,940	25

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										66,945	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ 66,945	14
15	TOTALS (line 9+line14)						$	$			$ 66,945	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2002 report. *Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$	37,417	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	41,295	2
3. Under or (over) accrual (line 2 minus line 1).	$	3,878	3
4. Real Estate Tax accrual used for 2003 report. (Detail and explain your calculation of this accrual on the lines below.)	$	38,754	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	42,632	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1998	30,021	8
	1999	30,232	9
	2000	34,887	10
	2001	38,556	11
	2002	39,854	12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2002	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2002 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2002 real estate tax costs, as well as copies of your real estate tax bills for calendar 2002.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2002 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2003 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2002 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME SHARON HEALTH CARE ELMS COUNTY Peoria

FACILITY IDPH LICENSE NUMBER 0032789

CONTACT PERSON REGARDING THIS REPORT Rick Duros

TELEPHONE (847)441-8200 FAX #: (847)441-0800

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2002 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2002.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	13-25-426-016	Nursing Home Property	$ 37,625.00	$ 37,625.00
2.	See Attached	Home Office	$ 8,753.00	$ 1,466.00
3.	See Attached	Building Co.	$ 61,167.00	$ 2,204.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 107,545.00	$ 41,295.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2002 tax bills which were listed in Section A to this statement. Be sure to use the 2002 tax bill which is normally paid during 2003.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 24,372 B. General Construction Type: Exterior Brick Frame _____ Number of Stories 1

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Sharon Healthcare Willows- Facility - 219 beds
Sharon Healthcare Woods- Facility - 152 beds
Sharon Healthcare Pines -Facility - 120 beds
Peoria Forest - Central Dietary (Formerly Unit Six Partnership)

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility			$ 107,214	1
2	Allocation - Peoria Forest			6,024	2
3	TOTALS			$ 113,238	3

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1987	5,207	165	20	260	95	2,662	9
10	Various			1988	4,581	128	20	240	112	2,594	10
11	Various			1989	1,877	60	20	94	34	856	11
12	Various			1990	6,666	297	20	373	76	4,005	12
13	Various			1991	23,422	777	20	1,189	412	9,760	13
14	Various			1992	19,136	642	20	974	332	7,316	14
15	Various			1994	9,731	250	20	487	237	2,330	15
16	Various			1995	2,723	69	20	136	67	583	16
17	Various			1996	4,103	106	20	206	100	796	17
18	Various			1997	19,387	497	20	970	473	3,138	18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		1991		$ 1,862,634	$ 59,139	35	$ 59,139	$	$ 633,277	4
5			1991		39,368	1,187	31.5	1,188	1	1,782	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68	Related Party Allocations(Page 12-Rep & Page 12A-Rep)		1,902,001	60,326		60,326		635,059	68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,998,834	$ 63,317		$ 65,255	$ 1,938	$ 669,099	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,998,834	$ 63,317		$ 65,255	$ 1,938	$ 669,099	1
2	Rooftop Heat/Cool	1998	5,147	132	20	257	125	787	2
3	Lawn Repair	1998	625	16	20	31	15	90	3
4	Water Softener	1998	1,700	44	20	85	41	243	4
5	Phone Shelf	1998	207	5	20	10	5	29	5
6	Rooftop Unit	1998	1,472	38	20	74	36	206	6
7	Amer II Minuteman	1998	272	7	20	14	7	38	7
8	Patio Ramp	1998	538	14	20	27	13	74	8
9	Roofing	1998	3,187	82	20	159	77	426	9
10	Drapes	1998	5,805	149	20	290	141	751	10
11	Heat Condenser	1999	1,203	31	20	60	29	149	11
12	Windows	1999	81	2	20	4	2	10	12
13	Garage Door	1999	142	4	20	7	3	18	13
14	Cubicle Tracking	1999	3,724	95	20	186	91	456	14
15	Cubicle Curtains	1999	2,586	66	20	129	63	317	15
16	Windows	1999	481	12	20	24	12	59	16
17	Concrete Parking Lot	1999	969	25	20	48	23	103	17
18	Roof	1999	996	26	20	50	24	1,069	18
19	Replace Drain Lines	1999	1,993	51	20	100	49	206	19
20	Repipe Water Lines	1999	1,601	41	20	80	39	166	20
21	Renovation Design	2000	2,561	66	20	128	62	233	21
22	Renovation Design	2000	1,950	50	20	98	48	169	22
23	Garbage Disposal	2000	791	20	20	40	20	67	23
24	Water Heater	2000	345	9	20	17	8	29	24
25	Parking Spaces	2000	89	2	20	4	2	7	25
26	Parking Spaces	2000	3,720	95	20	186	91	306	26
27	drapery	2000	5,588	143	20	279	136	448	27
28	Nurse Call Station	2000	3,544	91	20	177	86	284	28
29	Renovation Project	2000	398	10	20	20	10	30	29
30	Electrical Work	2001	1,427	37	20	71	34	105	30
31	Handicap Bathrooms	2001	25,250	647	20	1,263	616	1,807	31
32	Exit Door	2001	2,391	61	20	120	59	171	32
33	Renovation Design	2001	2,864	73	20	143	70	205	33
34	TOTAL (lines 1 thru 33)		$ 2,082,481	$ 65,461		$ 69,437	$ 3,976	$ 678,157	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 2,082,481	$ 65,461		$ 69,437	$ 3,976	$ 678,157	1
2	Garage	2001	965	25	20	48	23	69	2
3	Drapery	2001	6,320	162	20	316	154	425	3
4	Install Drapery	2001	662	17	20	33	16	45	4
5	Garage/Rework Trsh C	2001	1,219	31	20	61	30	82	5
6	Gas Water Heater	2001	2,481	64	20	124	60	156	6
7	Compact Water Booster	2001	1,247	32	20	62	30	79	7
8	Drapery	2001	1,622	42	20	81	39	102	8
9	Install Roof	2001	4,357	112	20	218	106	274	9
10	Repair-A/C Compressor	2001	966	25	20	48	23	59	10
11	Water Heater	2001	4,496	115	20	225	110	264	11
12	Replace Shingles	2001	923	24	20	46	22	54	12
13	Replace Refrig System	2001	1,092	28	20	55	27	62	13
14	Replace Shingles	2001	1,221	31	20	61	30	69	14
15	Flooring	2001	90	2	20	5	3	5	15
16	Parking Posts	2002	281	7	20	14	7	12	16
17	2 Exit Doors	2002	769	20	20	38	18	22	17
18	Roof Repair	2003	961	9	20	48	39	9	18
19	Dry Wall Repair	2003	1,672	9	20	84	75	9	19
20	Dining Room Roof-Roof Top	2003	1,943	10	20	97	87	10	20
21	Duct Work	2003	2,598	3	20	130	127	3	21
22	Flooring	2003	3,190	3	20	160	157	3	22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 2,121,556	$ 66,232		$ 71,391	$ 5,159	$ 679,970	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 63,803	$ 6,901	$ 11,393	$ 4,492	10	$ 53,408	71
72	Current Year Purchases	25,029	12,615	3,610	(9,005)	10	12,615	72
73	Fully Depreciated Assets	148,512				10	148,512	73
74								74
75	TOTALS	$ 237,344	$ 19,516	$ 15,003	$ (4,513)		$ 214,535	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76		1996 Chevy Van	2001	$ 2,463	$ 473	$ 493	$ 20	5	$ 1,754	76
77										77
78										78
79										79
80	TOTALS			$ 2,463	$ 473	$ 493	$ 20		$ 1,754	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,474,601	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 86,221	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 86,887	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 666	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 896,259	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5	Alloc.-Barton Mgmt				7,066			5
6								6
7	TOTAL				$ 7,066 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2004	$
13.	/2005	$
14.	/2006	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 13,272 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	Facility	2001 Dodge Ram	$ 83.00	$ 993	17
18					18
19					19
20					20
21	TOTAL		$ 83.00	$ 993	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

			1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition		$	$	$	$
2	Books and Supplies		320	320		640
3	Classroom Wages	(a)				
4	Clinical Wages	(b)				
5	In-House Trainer Wages	(c)				
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests		37	37		74
9	TOTALS		$ 357	$ 357	$	$ 714
10	SUM OF line 9, col. 1 and 2	(e)	$ 714			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$ 1,065

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	1
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	1
2. From other facilities (f)	
TOTAL TRAINED	2

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number SHARON HEALTH CARE ELMS **#** 0032789 **Report Period Beginning:** 1/1/03 **Ending:** 12/31/03

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/03 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 398,123	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	234,459		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	23,845		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	50,000		8
9	Other(specify):	184		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 706,611	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost	219,552		15
16	Equipment, at Historical Cost	239,804		16
17	Accumulated Depreciation (book methods)	(260,237)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 199,119	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 905,730	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 43,697	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	60,885		30
31	Accrued Taxes Payable (excluding real estate taxes)	9,615		31
32	Accrued Real Estate Taxes(Sch.IX-B)	38,754		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental schedule	774,390		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 927,341	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 927,341	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (21,611)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 905,730	$	48

***(See instructions.)**

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 273,482	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 273,482	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(295,093)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (295,093)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (21,611)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,852,484	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,852,484	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	38,756	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 38,756	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	1,136	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 1,136	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	1,938	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,938	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,894,314	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	746,657	31
32	Health Care	1,647,689	32
33	General Administration	557,217	33
	B. Capital Expense		
34	Ownership	184,189	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,189,407	40
41	**Income before Income Taxes (line 30 minus line 40)****	(295,093)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (295,093)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No/CashBasis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,080	2,080	$ 54,214	$ 26.06	1
2	Assistant Director of Nursing	1,416	1,560	28,828	18.48	2
3	Registered Nurses	20,915	22,337	419,798	18.79	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	63,436	67,609	747,081	11.05	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,932	8,724	92,495	10.60	8
9	Activity Director					9
10	Activity Assistants	5,480	5,680	41,990	7.39	10
11	Social Service Workers	5,997	6,434	67,070	10.42	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	15,206	16,284	168,654	10.36	15
16	Dishwashers					16
17	Maintenance Workers	5,896	5,989	57,893	9.67	17
18	Housekeepers	12,774	13,859	107,014	7.72	18
19	Laundry	7,908	8,691	72,688	8.36	19
20	Administrator	2,080	2,080	66,569	32.00	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,383	6,999	97,801	13.97	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,059	2,187	20,397	9.33	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	159,562	170,513	$ 2,042,492 *	$ 11.98	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	104	$ 8,757	1-3	35
36	Medical Director	118	6,000	9-3	36
37	Medical Records Consultant	52	1,440	10-3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	98	3,600	10-3	39
40	Physical Therapy Consultant	303	10,632	10-3	40
41	Occupational Therapy Consultant	261	9,150	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	75	2,645	10-3	43
44	Activity Consultant	78	2,739	11-3	44
45	Social Service Consultant	48	1,680	12-3	45
46	Other(specify)				46
47	Psychiatric	58	3,054	12-3	47
48					48
49	TOTAL (lines 35 - 48)	1,195	$ 49,697		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Sherry Ford	Administrator	0	$ 66,569
Carolyn Burnett	Office	0	21,675
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 88,244

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Frost, Ruttenberg & Rothblatt	Accounting	$ 6,600
Alloc - Barton	Accounting	204
Alloc - Sharon Complex	Accounting	506
Alpha Data Services	Data Processing	3,916
LTC Solutions	Computer	1,320
Thresholds	Computer	2,151
Personnel Planners	Unemployment Consult.	1,116
Alloc - Barton	Professional Fees	990
Gary Weintraub	Legal	250
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 17,053

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,778
Unemployment Compensation Insurance	12,076
FICA Taxes	155,472
Employee Health Insurance	42,957
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Retirement Plan Contribution	1,036
Christmas Expense	
Employee Benefits	349
TOTAL (agree to Schedule V, line 22, col.8)	$ 261,668

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	2,119
Health Care Worker Background Check	
(Indicate # of checks performed 70.3)	492
Licenses, Fees & Permit	1,431
Dues & Subscriptions	485
ICLTC Dues	3,730
Promotional Advertising	1,197
Less: Public Relations Expense	( )
Non-allowable advertising	(1,194)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,260

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,355
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,355

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008
1	Painting & Decorating	2000	$ 29,580	4	$ 4,930	$ 9,860	$ 9,860	$ 4,930	$	$	$	$	$
2	Painting & Decorating	2002	1,005	4			168	335	335	168			
3	Painting & Decorating	2003	505	4				84	168	168	85		
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 31,090		$ 4,930	$ 9,860	$ 10,028	$ 5,349	$ 503	$ 336	$ 85	$	$

Facility Name & ID Number SHARON HEALTH CARE ELMS # 0032789 Report Period Beginning: 1/1/03 Ending: 12/31/03

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes, Cna only**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Il Council of Long Term Care $3,730**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **12,462** Line **10-2**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **53,655**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ _____ Has any meal income been offset against related costs? **N/A** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? _____
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.